

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/30/2014
NAME OF PROVIDER OR SUPPLIER HAMMOND COMMUNITY AMBULATORY CARE CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 2143 CALUMET AVENUE HAMMOND, IN 46394		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 012066</p> <p>Survey Date: 09/29/2014 & 09/30/2014</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Hammond Community Ambulatory Care Center is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: cloughlin 10/08/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE